

Marc V. Kalagian
Attorney at Law: 4460
Law Offices of Lawrence D. Rohlfing, Inc., CPC
12631 East Imperial Highway Suite C-115
Santa Fe Springs, CA 90670
Tel.: (562) 868-5886
Fax: (562) 868-8868
E-mail: marc.kalagian@rksslaw.com

Leonard Stone
Attorney at Law: 5791
Shook & Stone
710 South 4th Street
Las Vegas, NV 89101
Tel.: (702) 385-2220
Fax: (702) 384-0394
E-mail: Lstone@shookandstone.com

Attorneys for Plaintiff
Torrell Johnson

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

TORRELL JOHNSON,)	Case No.: 2:23-cv-01251-BNW
)	
Plaintiff,)	STIPULATION AND PROPOSED
)	ORDER FOR THE AWARD AND
vs.)	PAYMENT OF ATTORNEY FEES
)	AND EXPENSES PURSUANT TO
MARTIN O'MALLEY,)	THE EQUAL ACCESS TO JUSTICE
Commissioner of Social Security,)	ACT, 28 U.S.C. § 2412(d) AND
)	COSTS PURSUANT TO 28 U.S.C. §
Defendant.)	1920
)	
)	

TO THE HONORABLE BRENDA WEKSLER, MAGISTRATE JUDGE
OF THE DISTRICT COURT:

IT IS HEREBY STIPULATED, by and between the parties through their
undersigned counsel, subject to the approval of the Court, that Torrell Johnson
("Johnson") be awarded attorney fees in the amount of SIX THOUSAND TWO

1 HUNDRED FIFTY-TWO dollars and EIGHTY FOUR cents (\$6,252.84) under the
2 Equal Access to Justice Act (EAJA), 28 U.S.C. § 2412(d), and costs in the amount
3 of FOUR HUNDRED TWO dollars (\$402.00) under 28 U.S.C. § 1920. This
4 amount represents compensation for all legal services rendered on behalf of
5 Plaintiff by counsel in connection with this civil action, in accordance with 28
6 U.S.C. §§ 1920; 2412(d).

7 After the Court issues an order for EAJA fees to Johnson, the government
8 will consider the matter of Johnson's assignment of EAJA fees to Marc Kalagian.
9 The retainer agreement containing the assignment is attached as exhibit 1.
10 Pursuant to *Astrue v. Ratliff*, 130 S.Ct. 2521, 2529 (2010), the ability to honor the
11 assignment will depend on whether the fees are subject to any offset allowed under
12 the United States Department of the Treasury's Offset Program. After the order for
13 EAJA fees is entered, the government will determine whether they are subject to
14 any offset.

15 Fees shall be made payable to Johnson, but if the Department of the
16 Treasury determines that Johnson does not owe a federal debt, then the government
17 shall cause the payment of fees, expenses and costs to be made directly to Law
18 Offices of Lawrence D. Rohlfing, Inc., CPC, pursuant to the assignment executed
19 by Johnson.¹ Any payments made shall be delivered to Law Offices of Lawrence
20 D. Rohlfing, Inc., CPC. Counsel agrees that any payment of costs may be made
21 either by electronic fund transfer (ETF) or by check.

22 This stipulation constitutes a compromise settlement of Johnson's request for
23 EAJA attorney fees, and does not constitute an admission of liability on the part of
24

25 ¹ The parties do not stipulate whether counsel for the plaintiff has a cognizable lien
26 under federal law against the recovery of EAJA fees that survives the Treasury
Offset Program.

Defendant under the EAJA or otherwise. Payment of the agreed amount shall constitute a complete release from, and bar to, any and all claims that Johnson and/or Marc Kalagian including Law Offices of Lawrence D. Rohlring, Inc., CPC, may have relating to EAJA attorney fees in connection with this action.

This award is without prejudice to the rights of Marc Kalagian and/or the Law Offices of Lawrence D. Rohlring, Inc., CPC, to seek Social Security Act attorney fees under 42 U.S.C. § 406(b), subject to the savings clause provisions of the EAJA.

DATE: October 2, 2024 Respectfully submitted,

LAW OFFICES OF LAWRENCE D. ROHLRING, INC., CPC

/s/ Marc V. Kalagian

BY: _____
Marc V. Kalagian
Attorney for plaintiff
TORRELL JOHNSON

DATE: October 2, 2024

JASON M. FRIERSON
United States Attorney

/s/ Julie Cummings

JULIE CUMMINGS
Special Assistant United States Attorney
Attorneys for Defendant
MARTIN O'MALLEY, Commissioner of Social
Security (Per e-mail authorization)

ORDER

Approved and so ordered:

DATE: 10/4/2024



THE HONORABLE BRENDA WEKSLER
UNITED STATES MAGISTRATE JUDGE

DECLARATION OF MARC V. KALAGIAN

I, Marc V. Kalagian, declare as follows:

1. I am an attorney at law duly admitted to practice before this Court in this case. I represent Torrell Johnson in this action. I make this declaration of my own knowledge and belief.
2. I attach as exhibit 1 a true and correct copy of the retainer agreement with Torrell Johnson containing an assignment of the EAJA fees.
3. I attach as exhibit 2 a true and correct copy of the itemization of time in this matter.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Executed this October 2, 2024, at Santa Fe Springs, California.

/s/ Marc V. Kalagian

Marc V. Kalagian

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 12631 East Imperial Highway, Suite C-115, Santa Fe Springs, California 90670.

On this day of October 3, 2024, I served the foregoing document described as STIPULATION FOR THE AWARD AND PAYMENT OF ATTORNEY FEES AND EXPENSES PURSUANT TO THE EQUAL ACCESS TO JUSTICE ACT, 28 U.S.C. § 2412(d) AND COSTS PURSUANT TO 28 U.S.C. § 1920 on the interested parties in this action by placing a true copy thereof enclosed in a sealed envelope addressed as follows:

Mr. Torrell Johnson
9785 Skyscape Ave.
Las Vegas, NV 89178

I caused such envelope with postage thereon fully prepaid to be placed in the United States mail at Santa Fe Springs, California.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

I declare that I am employed in the office of a member of this court at whose direction the service was made.

Marc V. Kalagian
TYPE OR PRINT NAME

/s/ Marc V. Kalagian
SIGNATURE

**CERTIFICATE OF SERVICE
FOR CASE NUMBER 2:23-CV-01251-BNW**

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for this court by using the CM/ECF system on October 3, 2024.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system, except the plaintiff served herewith by mail.

/s/ Marc V. Kalagian

Marc V. Kalagian
Attorneys for Plaintiff

SOCIAL SECURITY REPRESENTATION AGREEMENT

This agreement was made on August 9, 2021, by and between the Law Offices of Rohlfig & Kalagian, LLP referred to as attorney and **Mr. Torrell Johnson, S.S.N. 8850**, herein referred to as Claimant.

1. Claimant employs and appoints Law Offices of Rohlfig & Kalagian, LLP to represent Claimant as Mr. Torrell Johnson's Attorneys at law in a Social Security claim regarding a claim for disability benefits and empowers Attorney to take such action as may be advisable in the judgment of Attorney, including the taking of judicial review.

2. In consideration of the services to be performed by the Attorney and it being the desire of the Claimant to compensate Attorney out of the proceeds shall receive **25% of the past due benefits** awarded by the Social Security Administration to the claimant or **such amount as the Commissioner may designate under 42 U.S.C. § 406(a)(2)(A) which is currently \$6,000.00**, whichever is **smaller**, upon successful completion of the case **at or before a first hearing decision from an ALJ**. If the Claimant and the Attorney are unsuccessful in obtaining a recovery, Attorney will receive no fee. This matter is subject expedited fee approval except as stated in ¶3.

3. The provisions of ¶ 2 only apply to dispositions at or before a first hearing decision from an ALJ. The fee for successful prosecution of this matter is **25% of the past due benefits awarded upon reversal of any unfavorable ALJ decision for work before the Social Security Administration**. Attorney shall petition for authorization to charge this fee in compliance with the Social Security Act for all time whether exclusively or not committed to such representation.

4. If this matter requires judicial review of any adverse decision of the Social Security Administration, the fee for successful prosecution of this matter is **a separate 25% of the past due benefits awarded upon reversal of any unfavorable ALJ decision for work before the court**. Attorney shall seek compensation under the Equal Access to Justice Act and such amount shall credit to the client for fees otherwise payable for that particular work. Client shall endorse such documents as are needed to pay Attorney any amounts under the EAJA and assigns such fee awards to Attorney.

5. Claimant shall pay all costs, including, but not limited to costs for medical reports, filing fees, and consultations and examinations by experts, in connection with the cause of action.

6. Attorney shall be entitled to a reasonable fee; notwithstanding the Claimant may discharge or obtain the substitution of attorneys before Attorney has completed the services for which he is hereby employed.

7. Attorney has made no warranties as to the successful termination of the cause of action, and all expressions made by Attorney relative thereto are matters of Attorney's opinion only.

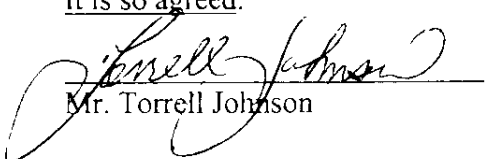
8. This Agreement comprises the entire contract between Attorney and Claimant. The laws of the State of California shall govern the construction and interpretation of this Agreement except that federal law governs the approval of fees by the Commissioner or a federal court. Business and Professions Code § 6147(a)(4) states "that the fee is not set by law but is negotiable between attorney and client."

9. Attorney agrees to perform all the services herein mentioned for the compensation provided above.

10. Client authorizes attorney to pay out of attorney fees and without cost to client any and all referral or association fees to James T. Crytzer, not to exceed 25% of fees.

11. The receipt from Claimant of none is hereby acknowledged by attorney to be placed in trust and used for costs.

It is so agreed.


Mr. Torrell Johnson

/s/ Marc V. Kalagian

Law Offices of Rohlfig & Kalagian, LLP
Marc V. Kalagian

WHOSE Records to be Disclosed

First Middle Last

NAME Mr. Torrell Johnson

SSN 439-53-8850

Birthday 12/30/1972

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN

**AUTHORIZATION TO DISCLOSE INFORMATION TO
THE LAW OFFICES OF ROHLFING & KALAGIAN, LLP****** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHATAll my records pertaining to workers' compensation benefits; state disability benefits; or other public benefit that affects the receipt of Social Security benefits.This includes specific permission to release:

- All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.
 - Gene-related impairments (including genetic test results)
- Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
- Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations
- Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social Workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers

Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:**TO WHOM
PURPOSE****Law Offices of Rohlfing & Kalagian, LLP including any employee thereof or photocopy service retained.**Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)**EXPIRES WHEN**

This authorization is good for 12 months from the date signed (below at my signature)

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to Rohlfing & Kalagian, LLP and my sources to revoke this authorization at any time (see page 2 for details).
- Rohlfing & Kalagian, LLP will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of the material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

INDIVIDUAL authorizing disclosure**SIGN** 

Date Signed

08-12-2024

Street Address

9785 Skyscape Ave.

Phone Number (with area code)
(808) 354-7787

City

Las Vegas

State

NV

ZIP

89178

IF not signed by subject of disclosure, specify basis for authority to sign

☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian sign here if two signatures required by State law)

WITNESS

I know the person signing this form or am satisfied of this person's identity:

SIGN 

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN 

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPPA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Mr. Torrell Johnson

12/30/1972

439-53-8850

Name

Date of Birth

Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME

ADDRESS

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number

_____ Identifying information (includes date and place of birth, parent's names)

_____ Monthly Social Security benefit amount

_____ Monthly Supplemental Security Income payment amount

_____ Information about benefits/payments I received from _____ to _____

_____ Information about my Medicare claim/coverage from _____ to _____

_____ (specify) _____

_____ Medical records

_____ Record(s) from my file (specify) _____

_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

(Show signatures, names, and addresses of two people if signed by a mark.)

Date: _____

Relationship: _____

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)
 (Take or mail original and all copies to your local Social Security office,
 the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post)

See Privacy Act
 Notice on Reverse

1. CLAIMANT Torrell Johnson	2. WAGE EARNER, IF DIFFERENT
3. SOCIAL SECURITY CLAIM NUMBER 439-53-8850	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (Complete ONLY in Supplemental Security Income Cases)

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

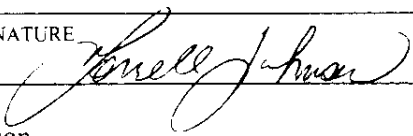
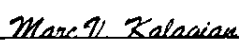
Please see the attached letter.

ADDITIONAL EVIDENCE

If you have additional evidence, submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.

SIGNATURE BLOCKS: You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

DATE	<input checked="" type="checkbox"/> ATTORNEY <input type="checkbox"/> NON-ATTORNEY
6. CLAIMANT'S SIGNATURE 	7. REPRESENTATIVE'S SIGNATURE 
PRINT NAME Mr. Torrell Johnson	PRINT NAME Marc V. Kalagian
ADDRESS 9785 Skyscape Ave.	ADDRESS 211 East Ocean Boulevard, Suite 420
(CITY, STATE, ZIP CODE) Las Vegas, NV 89178	(CITY, STATE, ZIP CODE) Long Beach CA, 90802
TELEPHONE NUMBER (INCLUDE AREA CODE) (808) 354-7787	TELEPHONE NUMBER (INCLUDE AREA CODE) (562) 437-7006

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ by: _____
 (Date) (Print Name)

(Title)	(Address)	Servicing FO Code	PC Code
9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? <input type="checkbox"/> Yes <input type="checkbox"/> No			

10. If no checked: (1) attach claimant's explanation for delay; and
 (2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

11. Check one: <input type="checkbox"/> Initial Entitlement <input type="checkbox"/> Termination or other	12. Check all claim types that apply: <input type="checkbox"/> Retirement or survivors (RSI) <input type="checkbox"/> Disability - Worker (DIWC) <input type="checkbox"/> Disability - Widow(er) (DIWW) <input type="checkbox"/> Disability - Child (DIWC) <input type="checkbox"/> SSI Aged (SSIA) <input type="checkbox"/> SSI Blind (SSIB) <input type="checkbox"/> SSI Disability (SSIB) <input type="checkbox"/> Health Insurance - Part A (SSID) <input type="checkbox"/> Health Insurance - Part B (HIA) <input type="checkbox"/> Title VIII Only (HIB) <input type="checkbox"/> Title VIII/Tutke XVI (SVB) <input type="checkbox"/> Other -- Specify: _____ (SVB-SSI)
APPEALS COUNCIL OFFICE OF HEARINGS AND APPEALS, SSA 5107 Leesburg Pike FALLS CHURCH, VA 22041-3255	

Form **SSA-1696** (08-2020) UF
 Discontinue Prior Editions
 Social Security Administration

Page 3 of 6
 OMB No. 0960-0527

Claimant's Social Security Number
 439-53-8850

Appointed Representative's Rep ID
 277Q25RLNM

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

First Name	Initial	Last Name
Torrell		Johnson

Mailing Address
 9785 Skyscape Ave.

City	State	ZIP/Postal Code	Country – if outside the U.S.
Las Vegas	NV	89178	

Phone Number	Alternate Phone Number (Optional)
(808) 354-7787	

Country/Area Code	Phone Number	Country/Area Code	Phone Number

Number Holder's Information (Complete when applicable)

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

First Name	Initial	Last Name

Section 2 - Disclosure (Claimant Only)

- ☒ By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. *(The appointed representative's partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)*

Section 3 - Principal Representative (Claimant only – Complete when applicable)

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name Marc V. Kalagian

Form SSA-1696 (08-2020) UF

Page 4 of 6

Claimant's Social Security Number
439-53-8850Appointed Representative's Rep ID
277Q25RLNM**Section 4 - Representative's Information (Claimant and Representative)**

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

First Name

Marc

Initial**Last Name**

Kalagian

Mailing Address

211 East Ocean Boulevard, Suite 420

City

Long Beach

State

CA

ZIP/Postal Code

90802

Country – if outside the U.S.**Phone Number**

(562) 437-7006

Alternate Phone Number (Optional)**Country/Area Code****Phone Number****Country/Area Code****Phone Number****Section 5 - Representative's Status, Affiliations, and Certifications (Representative Only)**

Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

☒ I am an attorney (SSA law states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)

☐ I am a non-attorney eligible for direct payment (SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).

☐ I am a non-attorney not eligible for direct payment.

☐ I work for non-profit organization (e.g. a law clinic or state legal aid)

Representative's Status Part B – Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

☐ Yes ☒ No

Form SSA-1696 (08-2020) UF

Page 5 of 6

Claimant's Social Security Number
439-53-8850Appointed Representative's Rep ID
277Q25RLNM**Section 5 – Continued (Representative Only)****Affiliation Information**

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. *(Do not complete this section if you do not qualify for direct payment.)*

EIN
45-5627830

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

Rohlfing & Kalagian, LLP

Representative's Business Address (if different than mailing address)

City

State

ZIP/Postal Code

Country – if outside the U.S.

Representative's Certifications

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE **MVK** (Representative's Initials)

Form SSA-1696 (08-2020) UF

Page 6 of 6

Claimant's Social Security Number
439-53-8850Appointed Representative's Rep ID
277Q25RLNM**Section 6 - Claim Type (Claimant or Representative)**

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title II (RSDI), Title XVI (SSI), Title XVIII (Medicare Coverage), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: *(Check all that apply)*

- ☐ Claim/Appeal for Title II Disability Benefits
- ☐ Claim/Appeal for Title XVI Disability Benefits
- ☒ Concurrent Title II and Title XVI Disability Benefits
- ☐ Claim/Appeal for Retirement Benefits
- ☐ Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran's Benefits)
- ☐ Continuing Disability Review (CDR)
- ☐ Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement (Representative Only)

Check one box below:

- ☒ **I will request a fee and direct payment of this fee.** Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*
- ☐ **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*
- ☐ **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- ☐ **I waive the right to a fee.**

Section 8 - Signatures (Claimant and Representative)

Representative's Signature

Date
August 9, 2021

Claimant's Signature


Date
August 9, 2021

Client Intake Sheet**Note to Attorney: Modify this as needed**

Attorney: _____

Date Form Completed: 08.12.2021**Client Information**Name: Torrell Johnson Parent or Guardian(if Minor) _____Address/Domicillio: 9785 SkyScape AveCity, State, Zip Code: _____
Cuidad, Estado, Zona Postal Las Vegas Nevada 89178Home Telephone: _____ Cellular Telephone: (808) 354-7797Email: nchdogg1@gmail.comSocial Security Number 139-53-8850 Date of Birth 12-30-1972

Numero del seguro social _____ Fecha de nacimiento _____

Marital Status/Estado Civil: Single/Soltero/a ☒ Married/Casado/a ☐ Divorced/Divorciado/a ☐ Other : _____Are you a United States Citizen Yes ☒ No ☐ If no what is your status: _____Place of Birth(city & state): Honolulu, HI Mother's Maiden Name: EveryDate you last Worked: Nov 14, 2017 How many total years have you worked: 27
Ultimo dia trabajado _____ Numero de anos trabajados _____What language do you speak? Check all that apply: English ☒ Spanish ☐ Other: _____**Name, address and phone number of someone who will always be able to contact you:**Name: Shanel K. JohnsonAddress: 9785 SkyScape Ave Las Vegas NV, 89178Home Telephone: _____ Cellular Telephone: (808) 354-7799Referred By: Client ☐ Attorney ☒ Other _____

Torrell Johnson

Social Security case

Responsible Attorney Brian C. Shapiro at \$244.62 Supervising Attorney MVK at \$244.62

Paralegal: Enny Perez a at \$179

<u>DATE:</u>	<u>TIME:</u>	<u>PLGL:</u>	<u>DESCRIPTION:</u>
27-Jul-23	0.2	EP	receipt of IFP forms, review for IFP eligibility and review of letter from client
11-Aug-23	0.4	EP	review and filing of complaint to review the final decision of the Commissioner
14-Aug-23	0.2	EP	preparation of consent
19-Oct-23	0.2	EP	preparation of letter to client with status
10-Oct-23	0.2	EP	review of notice of appearance
10-Oct-23	0.9	EP	receipt of transcript; OCR, preparation of memorandum to LDR regarding same
7-Dec-23	0.2	EP	preparation of status report to client
28-Aug-24	0.1	EP	receipt of judgment
28-Aug-24	0.1	EP	receipt of memorandum and opinion
Subtotals	2.50		\$447.50

<u>DATE:</u>	<u>TIME:</u>	<u>ATTY:</u>	<u>DESCRIPTION:</u>
7-Jul-23	0.9	BCS	review of AC decision
7-Jul-23	0.5	MVK	review of AC decision re DC appeal
10-Jul-23	0.5	BCS	preparatoin of letter to client re: DC
28-Jul-23	0.1	MVK	review of IFP
28-Jul-23	0.3	MVK	review of complaint
10-Oct-23	0.1	BCS	receipt and review of memorandum from EP re: memorandum
29-Oct-23	4.4	BCS	beginning of opening brief

30-Oct-23	6.4	BCS	continuation of Opening Brief	
1-Nov-23	4.7	BCS	completion	
2-Nov-23	0.3	MVK	review, edit and filing of brief	
6-Dec-23	3.7	BCS	review of counter motion and preparation of reply	
7-Dec-23	0.5	MVK	review, edit of reply	
30-Aug-24	0.4	MVK	review of decision	
9-Sep-24	0.4	BCS	review of decision	
9-Sep-24	0.2	BCS	preparation of letter to client regarding District Court	
9-Sep-24	0.7	BCS	preparation of EAJA request	
Subtotals	24.1			
				447.5
	\$244.62			\$5,895.34
TOTAL EAJA				\$6,342.84